FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042093

Facility Name: RENAISSANCE AT 87TH ST THE

Address: 2940 WEST 87TH STREE (Number) CHICAGO (City) 60652 (Zip Code)

County: COOK

Telephone Number: (773) 434-8787 **Fax #** (773) 434-8717

IDPA ID Number: 363945570001

Date of Initial License for Current Owners: 07/19/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	204	Skilled (SNF)	204	74,460	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	37,693	3,054	14,860	55,607	8
9	SNF/PED					9
10	ICF	10,325	1,585	347	12,257	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,018	4,639	15,207	67,864	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.14%

D. How many bed-hold days during this year were paid by Public Aid?
2,345 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/21/1999

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date NEW CONSTRUCION NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 78 and days of care provided 8380

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	268,469	67,478	8,755	344,702		344,702	23	344,725			1
2	Food Purchase		340,260		340,260	(30,514)	309,746	(1,954)	307,792			2
3	Housekeeping	193,965	50,636	(11,853)	232,748		232,748		232,748			3
4	Laundry	61,447	21,885		83,332		83,332		83,332			4
5	Heat and Other Utilities			145,589	145,589		145,589	(11,765)	133,824			5
6	Maintenance	83,148	24,643	152,367	260,158		260,158	1,549	261,707			6
7	Other (specify):*							29	29			7
8	**TOTAL General Services**	607,029	504,902	294,858	1,406,789	(30,514)	1,376,275	(12,118)	1,364,157			8
	B. Health Care and Programs											
9	Medical Director			45,000	45,000		45,000		45,000			9
10	Nursing and Medical Records	2,729,177	242,761	586,659	3,558,597		3,558,597	804	3,559,401			10
10a	Therapy	50,706	60	3,803	54,569		54,569		54,569			10a
11	Activities	201,954	23,040	1,578	226,572		226,572		226,572			11
12	Social Services	83,431		303	83,734		83,734		83,734			12
13	Nurse Aide Training			19,837	19,837		19,837		19,837			13
14	Program Transportation			1,755	1,755		1,755	333	2,088			14
15	Other (specify):*							66	66			15
16	**TOTAL Health Care and Programs**	3,065,268	265,861	658,935	3,990,064		3,990,064	1,203	3,991,267			16
	C. General Administration											
17	Administrative	206,441		588,097	794,538		794,538	(320,111)	474,427			17
18	Directors Fees											18
19	Professional Services			107,986	107,986		107,986	(18,704)	89,282			19
20	Dues, Fees, Subscriptions & Promotions			168,225	168,225		168,225	(83,142)	85,083			20
21	Clerical & General Office Expenses	316,743	72,407	144,884	534,034		534,034	75,244	609,278			21
22	Employee Benefits & Payroll Taxes			681,657	681,657	30,514	712,171	(27,500)	684,671			22
23	Inservice Training & Education											23
24	Travel and Seminar			31,657	31,657		31,657	(25,813)	5,844			24
25	Other Admin. Staff Transportation			613	613		613	309	922			25
26	Insurance-Prop.Liab.Malpractice			150,443	150,443		150,443	535	150,978			26
27	Other (specify):*							31,588	31,588			27
28	**TOTAL General Administration**	523,184	72,407	1,873,562	2,469,153	30,514	2,499,667	(367,594)	2,132,073			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,195,481	843,170	2,827,355	7,866,006		7,866,006	(378,509)	7,487,497			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE #0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			61,647	61,647		61,647	288,112	349,759			30
31	Amortization of Pre-Op. & Org.							8,208	8,208			31
32	Interest			299,120	299,120		299,120	793,222	1,092,342			32
33	Real Estate Taxes							394,289	394,289			33
34	Rent-Facility & Grounds			2,645,241	2,645,241		2,645,241	(2,634,817)	10,424			34
35	Rent-Equipment & Vehicles			3,655	3,655		3,655	7,856	11,511			35
36	Other (specify):*							31,370	31,370			36
37	**TOTAL Ownership**			3,009,663	3,009,663		3,009,663	(1,111,760)	1,897,903			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	12,636	390,932	69,999	473,567		473,567	37	473,604			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690		111,690		111,690			42
43	Other (specify):*	71,835			71,835		71,835	(71,835)				43
44	**TOTAL Special Cost Centers**	84,471	390,932	181,689	657,092		657,092	(71,798)	585,294			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,279,952	1,234,102	6,018,707	11,532,761		11,532,761	(1,562,067)	9,970,694			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,486)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(154,873)	30		9
10	Interest and Other Investment Income	(9,019)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(233)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(26,298)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(78)	21		18
19	Entertainment				19
20	Contributions	(20,000)	20		20
21	Owner or Key-Man Insurance	(27,500)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,014)	21		24
25	Fund Raising, Advertising and Promotional	(74,070)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(260)	20		28
29	Other-Attach Schedule	(118,519)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (511,350)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,050,717)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,050,717)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,562,067)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

RENAISSANCE AT 87TH ST THE

ID# 0042093

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BANK CHARGES	$ (806)	21	1
2	IL COUNCIL ON LTC - COPE	(1,712)	20	2
3	MARKETING DIRECTOR	(59,852)	43	3
4	VP MARKETING	(11,983)	43	4
5	MISC. INCOME - MEALS	(1,721)	02	5
6	MISC. INCOME - COPIES	(175)	21	6
7	MISC. INCOME - JURY DUTY	(86)	21	7
8	LEGAL FEES - BUILDING CO.	(327)	19	8
9	ACCOUNTING FEES - BUILDING CO.	(10,152)	19	9
10	NON-ALLOWABLE SEMINAR	(866)	24	10
11	PPA - OFFICE	(8,000)	21	11
12	PPA - OFFICE (retained earnings restatement)	(678)	21	12
13	Prior Period Legal Expense	(14,366)	19	13
14	Collection Expense	(7,795)	19	14
15				15
16				16
17				17
18				18
19				19
20				20
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92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
	Total	(118,519)		

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			23									23	1
2	Food Purchase	(1,954)											(1,954)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(12,486)		721									(11,765)	5
6	Maintenance			1,549									1,549	6
7	Other (specify):*			29									29	7
8	**TOTAL General Services**	(14,440)		2,322									(12,118)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			804									804	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			333									333	14
15	Other (specify):*			66									66	15
16	**TOTAL Health Care and Programs**			1,203									1,203	16
	C. General Administration													
17	Administrative			1,511	(181,184)	(111,698)		(28,740)					(320,111)	17
18	Directors Fees													18
19	Professional Services	(32,640)	11,446	1,201				1,289					(18,704)	19
20	Fees, Subscriptions & Promotions	(96,042)	1,800	671				10,429					(83,142)	20
21	Clerical & General Office Expenses	(77,837)		149,573		257		3,251					75,244	21
22	Employee Benefits & Payroll Taxes	(27,500)											(27,500)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(27,164)		1,313				38					(25,813)	24
25	Other Admin. Staff Transportation			309									309	25
26	Insurance-Prop.Liab.Malpractice			535									535	26
27	Other (specify):*			22,046	2,729	371		6,442					31,588	27
28	**TOTAL General Administration**	(261,183)	13,246	177,159	(178,455)	(111,070)		(7,291)					(367,594)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(275,623)	13,246	180,684	(178,455)	(111,070)		(7,291)					(378,509)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(154,873)	438,323	4,662									288,112	30
31	Amortization of Pre-Op. & Org.		8,208										8,208	31
32	Interest	(9,019)	804,940	(2,699)									793,222	32
33	Real Estate Taxes		394,289										394,289	33
34	Rent-Facility & Grounds		(2,645,241)	10,424									(2,634,817)	34
35	Rent-Equipment & Vehicles			7,856									7,856	35
36	Other (specify):*		31,370										31,370	36
37	TOTAL Ownership	(163,892)	(968,111)	20,243									(1,111,760)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			37									37	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(71,835)											(71,835)	43
44	TOTAL Special Cost Centers	(71,835)		37									(71,798)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(511,350)	(954,865)	200,964	(178,455)	(111,070)		(7,291)					(1,562,067)	45

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				RENAISSANCE AT BEVERLY LP		BLDG PRTNRSHP

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 2,645,241	RENAISSANCE AT BEVERLY LP		$	$ (2,645,241)	1
2	V	32	INTEREST INCOME	1,405				(1,405)	2
3	V	20	FEES				1,800	1,800	3
4	V	19	LEGAL				327	327	4
5	V	19	ACCOUNTING FEES				11,119	11,119	5
6	V	32	INTEREST EXPENSE				740,440	740,440	6
7	V	33	REAL ESTATE TAXES				394,289	394,289	7
8	V	36	MIP INSURANCE				31,370	31,370	8
9	V	30	DEPRECIATION				438,323	438,323	9
10	V	31	AMORTZ. OF ORG. COSTS				1,842	1,842	10
11	V	31	AMORTZ. OF HUD LOAN FEES				6,366	6,366	11
12	V	32	INTEREST - ITEX VENTURE				57,229	57,229	12
13	V	32	INTEREST - REN @ 87TH INC				8,676	8,676	13
14	Total			$ 2,646,646			$ 1,691,781	$ * (954,865)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	NUCARE SERVICES CORP.	100.00%	$ 23	$ 23	15
16	V	5	UTILITIES				721	721	16
17	V	6	REPAIRS AND MAINT.				1,549	1,549	17
18	V	7	EMPLOYEE BEN. GEN. SERV.				29	29	18
19	V	10	NURSING ADMIN. COMP.				804	804	19
20	V	14	PROGRAM TRANSPORTATION				333	333	20
21	V	15	HEALTHCARE BENEFITS				66	66	21
22	V	17	ADMINISTRATIVE - NON-OWNER				1,511	1,511	22
23	V	19	PROFESSIONAL FEES				1,201	1,201	23
24	V	20	FEES SUBSCRIPTIONS				671	671	24
25	V	21	CLERICAL & GENERAL				149,573	149,573	25
26	V	24	SEMINARS AND EDUCATION				1,313	1,313	26
27	V	25	ADMIN. STAFF TRAVEL				309	309	27
28	V	26	INSURANCE				535	535	28
29	V	27	EMPLOYEE BEN. GEN. ADMIN.				22,046	22,046	29
30	V	30	DEPRECIATION				4,662	4,662	30
31	V	32	INTEREST EXPENSE				(2,699)	(2,699)	31
32	V	34	BUILDING RENT				10,424	10,424	32
33	V	35	EQUIPMENT RENTAL				7,856	7,856	33
34	V	39	ANCILLARY				37	37	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 200,964	$ * 200,964	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	$	NUCARE SERVICES CORP.	100.00%	$ 79,727	$ 79,727	15
16	V	17	ADMIN. - B. CARR				19,545	19,545	16
17	V	17	ADMIN. - D. HARTMAN				2,169	2,169	17
18	V	17	ADMIN. - E. DICKMAN						18
19	V	27	EMP. BEN. - R. HARTMAN				1,720	1,720	19
20	V	27	EMP. BEN. - B. CARR				840	840	20
21	V	27	EMP. BEN. - D. HARTMAN				169	169	21
22	V	27	EMP. BEN. - E. DICKMAN						22
23	V								23
24	V								24
25	V	17	MANAGEMENT FEES	282,625				(282,625)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 282,625			$ 104,170	$ * (178,455)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR MANAGEMENT CORP.	100.00%	$ 8,302	$ 8,302	15
16	V	21	OFFICE				257	257	16
17	V	27	PAYROLL TAXES				371	371	17
18	V								18
19	V								19
20	V								20
21	V	17	MARVIN NEEDLE-CONS. FEES						21
22	V								22
23	V								23
24	V	17	MARK BERGER-CONS. FEES						24
25	V	21	SECRETARIAL						25
26	V								26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	120,000				(120,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 120,000			$ 8,930	$ * (111,070)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	WORKERS COMPENSATION	$ 49,701	DIAMOND INSURANCE		$ 49,701	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 49,701			$ 49,701	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 36,732	$ 36,732	15
16	V	19	PROFESSIONAL FEES				1,289	1,289	16
17	V	20	FEES, SUBSCRIPTIONS				10,429	10,429	17
18	V	21	CLERICAL AND GENERAL				3,251	3,251	18
19	V	24	SEMINARS				38	38	19
20	V	27	GEN ADMIN.- EMP. BEN.				6,442	6,442	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	65,472				(65,472)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 65,472			$ 58,181	$ * (7,291)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HARTMAN	OWNER	ADMIN	20.05%	SEE ATTACHED	4.04	6.22%	MGMT. FEE	$ 120,000	17-3	1
2	ROBERT HARTMAN	OWNER	ADMIN	20.05%	SEE ATTACHED	4.04	6.22%	NUCARE	79,727	17-7	2
3	BARRY CARR	PRESIDENT	ADMIN	NONE	SEE ATTACHED	4.4	9.78%	SALARY	36,329	17-1	3
4	BARRY CARR	PRESIDENT	ADMIN	NONE	SEE ATTACHED	4.4	9.78%	NUCARE	19,545	17-7	4
5	DAVID HARTMAN	RELATIVE	ADMIN	NONE	SEE ATTACHED	.6	1.30%	NUCARE	2,169	17-7	5
6	BERNARD HOLLANDER	OWNER	ADMIN	25.00%	SEE ATTACHED	2	3.10%	N/A	NONE	N/A	6
7	JACK RAJCHENBACH	OWNER	ADMIN	25.00%	SEE ATTACHED	3	4.60%	JLR MGMT	8,302	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 266,072		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAIL. CENSUS DAYS	672,540	8	$ 205	$	74,460	$ 23	1
2	5	UTILITIES	AVAIL. CENSUS DAYS	672,540	8	6,508		74,460	721	2
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	672,540	8	13,988	1,054	74,460	1,549	3
4	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	672,540	8	258		74,460	29	4
5	10	NURSING ADMIN. COMP.	AVAIL. CENSUS DAYS	672,540	8	7,261	2,431	74,460	804	5
6	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	672,540	8	3,009		74,460	333	6
7	15	HEALTHCARE BENEFITS	AVAIL. CENSUS DAYS	672,540	8	595		74,460	66	7
8	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	672,540	8	13,648	8,000	74,460	1,511	8
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	672,540	8	10,851		74,460	1,201	9
10	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	672,540	8	6,065		74,460	671	10
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	672,540	8	1,350,975	1,102,702	74,460	149,573	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	672,540	8	11,855		74,460	1,313	12
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	672,540	8	2,788		74,460	309	13
14	26	INSURANCE	AVAIL. CENSUS DAYS	672,540	8	4,831		74,460	535	14
15	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	672,540	8	199,124		74,460	22,046	15
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	672,540	8	42,107		74,460	4,662	16
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	672,540	8	(24,377)		74,460	(2,699)	17
18	34	BUILDING RENT	AVAIL. CENSUS DAYS	672,540	8	94,150		74,460	10,424	18
19	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	672,540	8	70,953		74,460	7,856	19
20	39	ANCILLARY	AVAIL. CENSUS DAYS	672,540	8	335	269	74,460	37	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,815,129	$ 1,114,456		$ 200,964	25

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	720,115	720,000	4.04	79,727	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	40.00	8	177,679	175,000	4.40	19,545	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	18,073	17,000	0.60	2,169	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	20,728	19,166			4
5	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	15,535		4.04	1,720	5
6	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	40.00	8	7,632		4.40	840	6
7	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	1,411		0.60	169	7
8	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	1,576				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 962,749	$ 931,166		$ 104,170	25

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JLR MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	61	9	$ 168,808	$ 168,808	3	$ 8,302	1
2	21	OFFICE	AVG. HOURS WORKED	61	9	5,235		3	257	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	61	9	7,543		3	371	3
4										4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	36,296				7
8										8
9										9
10	17	MARK BERGER-CONS. FEES	AVG. HOURS WORKED	50	2	10,000				10
11	21	SECRETARIAL	AVG. HOURS WORKED	50	2	5,000				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 232,882	$ 168,808		$ 8,930	25

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DIAMOND INSURANCE
Street Address: 40 SKOKIE BLVD - SUITE 105
City / State / Zip Code: NORTHBROOK IL 60062
Phone Number: (847) 559-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	DIAMOND INSURANCE	DIRECT ALLOCATION			$	$		$ 49,701	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 49,701	25

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	629,760	13	$ 353,316	$ 353,316	65,472	$ 36,732	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	629,760	13	12,396		65,472	1,289	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	629,760	13	100,317		65,472	10,429	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	629,760	13	31,275		65,472	3,251	4
5	24	SEMINARS	CARE PATH FEES	629,760	13	366		65,472	38	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	629,760	13	61,960		65,472	6,442	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 559,630	$ 353,316		$ 58,181	25

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	DUE TO SHAREHOLDERS	X					$	$ 1,499,000		9.50%	$ 107,190	1
2	MORTGAGE - BLDG. CO.	X						9,534,200			740,440	2
3	ITEX - BLDG. CO.	X									57,229	3
4	REN. @ 87TH - BLDG. CO.	X									8,676	4
5												5
	Working Capital											
6	AMERICAN NAT'L BANK		X								146,203	6
7	COLE TAYLOR BANK		X								22,042	7
8	CIB BANK		X								23,685	8
9	TOTAL Facility Related						$	$ 11,033,200			$ 1,105,465	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(13,123)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (13,123)	14
15	TOTALS (line 9+line14)						$	$ 11,033,200			$ 1,092,342	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOC. - NUCARE	X					$	$			$ (2,699)	1
2	INTEREST INC. - BLDG. CO.	X									(1,405)	2
3	INTEREST INCOME		X								(343)	3
4	INTEREST INC. - BLDG. CO.	X									(8,676)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (13,123)	21

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 275,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 329,699	2
3. Under or (over) accrual (line 2 minus line 1).		$ 54,699	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 339,590	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 394,289	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998	55,017	10
1999	144,392	11
2000	329,699	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RENAISSANCE AT 87TH ST THE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042093

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-36-322-011-0000	Long Term Care Property	$ 45,984.79	$ 45,984.79
2.	19-36-322-012-0000	Long Term Care Property	$ 58,232.82	$ 58,232.82
3.	19-36-322-013-0000	Long Term Care Property	$ 89,670.64	$ 89,670.64
4.	19-36-322-014-0000	Long Term Care Property	$ 64,520.54	$ 64,520.54
5.	19-36-322-015-0000	Long Term Care Property	$ 58,232.82	$ 58,232.82
6.	19-36-322-016-0000	Long Term Care Property	$ 8,471.47	$ 8,471.47
7.	19-36-322-017-0000	Long Term Care Property	$ 2,427.29	$ 2,427.29
8.	19-36-322-018-0000	Long Term Care Property	$ 2,159.07	$ 2,159.07
9.			$	$
10.			$	$
		TOTALS	$ 329,699.44	$ 329,699.44

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,911 B. General Construction Type: Exterior MASONRY/BRICK Frame STEEL Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 263,860
2. Number of Years Over Which it is Being Amortized: 5 YEARS, 40 YEARS
3. Current Period Amortization: 8,208
4. Dates Incurred: 7/99

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	51,162	1994	$ 703,613	1
2					2
3	TOTALS	51,162		$ 703,613	3

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	204		1999	1999	$ 8,932,245	$ 229,032	35	$ 223,306	$ (5,726)	$ 557,311	4
5			1999	1999	4,436	114	35	222	108	4,325	5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,638	137		129	(8)	328	68
69	Financial Statement Depreciation			3,707			(3,707)		69
70	TOTAL (lines 4 thru 69)		$ 8,939,319	$ 232,990		$ 223,657	$ (9,333)	$ 561,964	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,939,319	$ 232,990		$ 223,657	$ (9,333)	$ 561,964	1
2	FLAGPOLE	1999	1,471		20	74	74	185	2
3	SPRINKLER SYSTEM	1999	5,430		20	272	272	680	3
4	INDUSTRIAL FENCE	1999	1,449		20	72	72	180	4
5	WALLPAPER	1999	414		20	21	21	53	5
6	WALLPAPER	1999	464		20	23	23	58	6
7	PARKING LOT	1999	12,650		20	633	633	1,583	7
8	SECURITY VCR	1999	1,107		20	55	55	138	8
9	2 MONUMENTS	1999	10,288		20	514	514	1,285	9
10	AWNING	1999	5,260		20	263	263	658	10
11	CARPET	1999	3,709		20	185	185	463	11
12	TILE	1999	397		20	20	20	48	12
13	FENCE & GATES,BRICK	1999	19,870		20	994	994	2,402	13
14	LANDSCAPING	1999	4,915		20	246	246	595	14
15	TILE	1999	311		20	16	16	39	15
16	AIR CONDITIONING SYS	1999	1,235		20	62	62	145	16
17	3 ICE MACHINES	1999	470		20	24	24	56	17
18	WINDOW TREATMENTS	1999	1,613		20	81	81	189	18
19	ELECTRICAL WORK	1999	5,631		20	282	282	658	19
20	FENCE	1999	1,990		20	100	100	250	20
21	WALLCOVERING	1999	83		20	4	4	9	21
22	WINDOW TREATMENTS	1999	4,561		20	228	228	494	22
23	CORNICE BOARDS	1999	875		20	44	44	95	23
24	PARTITION WALL	1999	1,785		20	89	89	185	24
25	NURSES CALL SYS	1999	782		20	39	39	81	25
26	ELEVATOR	1999	1,531		20	77	77	160	26
27	SOLAR CONTROL PANELS	1999	777		20	20	20	40	27
28	WINDOW TRTMNT MRKTG	2000	784		20	20	20	39	28
29	BACK PATIO CANOPY	2000	8,627		20	221	221	359	29
30	IMPROVEMENT	2000	488		20	13	13	21	30
31	LANDSCAPING WORK	2000	2,486		20	64	64	93	31
32	2 LOCKS	2000	1,326		20	34	34	52	32
33	ELEVATOR REPAIR	2000	602		20	15	15	22	33
34	TOTAL (lines 1 thru 33)		$ 9,042,700	$ 232,990		$ 228,462	$ (4,528)	$ 573,279	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,042,700	$ 232,990		$ 228,462	$ (4,528)	$ 573,279	1
2	INSTLL 2 HNGS/ DR FR	2000	485		20	12	12	17	2
3	PATCH W/ASPHALT	2000	1,200		20	31	31	40	3
4	REPLACE BATTERIES	2000	791		20	20	20	26	4
5	CABLEING	2000	903		20	23	23	30	5
6	REPLACE FLOOR IN ELE	2000	1,750		20	45	45	58	6
7	SCREENS	2000	630		20	16	16	19	7
8	REPAIR TO FIRE ALARM	2000	985		20	25	25	28	8
9	WALLPAPER	2000	1,118		20	29	29	30	9
10	RERUN DRYER VENT LIN	2000	1,951		20	50	50	52	10
11	BOILER REPAIRS	2000	664		20	17	17	18	11
12	CUBICLE DIVIDERS,WOR	2000	3,667		20	94	94	106	12
13	WANDERGUARD	2000	15,500		20	397	397	645	13
14	INSTALL MOLDING	2000	480		20	12	12	22	14
15	PURIFIER FILTERS	2000	693		20	35	35	70	15
16	PARKING LOT R&M	2001	2,990		20	63	63	63	16
17	AIR CONDITIONERS	2001	6,100		20	76	76	76	17
18	LOWER LEVEL OFFICE	2001	19,450		20	243	243	243	18
19	CARPET	2001	1,100		20	14	14	14	19
20	WINDOW SHADES	2001	3,395		20	43	43	43	20
21	LIGHT FIXTURES	2001	808		20	10	10	10	21
22	AWNING R&M	2001	4,585		20	229	229	229	22
23	CHILLER R&M	2001	2,584		20	75	75	75	23
24	OUTSIDE STORAGE	2001	1,785		20	59	59	59	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,116,314	$ 232,990		$ 230,080	$ (2,910)	$ 575,252	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOC. - NUCARE MGMT.			1997	510	13	20	26	13	108	9
10	ALLOC. - NUCARE MGMT.			1998	447	11	20	22	11	77	10
11	ALLOC. - NUCARE MGMT.			1999	626	87	20	31	(56)	76	11
12	ALLOC. - NUCARE MGMT.			2000	761	19	20	38	(19)	55	12
13	ALLOC. - NUCARE MGMT.			2001	294	7	20	12	5	12	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,638	$ 137		$ 129	$ (46)	$ 328	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,172,737	$ 270,810	$ 117,755	$ (153,055)	10	$ 294,226	71
72	Current Year Purchases	47,496	832	1,924	1,092	10	1,924	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,220,233	$ 271,642	$ 119,679	$ (151,963)		$ 296,150	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,040,160	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 504,632	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 349,759	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (154,873)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 871,402	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 2,645,241			3
4	Additions							4
5	ALLOC. - NUCARE				10,424			5
6	RENAISSANCE AT BEVERLY LP				(2,645,241)			6
7	TOTAL				$ 10,424 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 11,511 Description: $3,655 TOSHIBA - COPIER, $7,856 ALLOC. FROM NUCARE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 120

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$ 209	$ 2,926	$	$ 3,135
2	Books and Supplies	55	771		826
3	Classroom Wages (a)				
4	Clinical Wages (b)	1,058	14,818		15,876
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 1,322	$ 18,515	$	$ 19,837
10	SUM OF line 9, col. 1 and 2 (e)	$ 19,837			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	15

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 28,156	$		$ 28,156	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			4,239			4,239	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			37,604			37,604	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				248,743		248,743	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):			12,636			142,189		154,825	13
14	TOTAL			$ 12,636		$ 69,999	$ 390,932		$ 473,567	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,736	$ 125,560	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,586,031	3,586,031	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	102,568	138,278	6
7	Other Prepaid Expenses	11,985	11,985	7
8	Accounts Receivable (owners or related parties)	395,167	395,167	8
9	Other(specify): See supplemental schedule	24,627	307,614	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,123,114	$ 4,564,635	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		703,613	13
14	Buildings, at Historical Cost		8,936,681	14
15	Leasehold Improvements, at Historical Cost	162,046	162,046	15
16	Equipment, at Historical Cost	235,792	1,204,205	16
17	Accumulated Depreciation (book methods)	(123,726)	(1,341,690)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		9,211	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(4,528)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	8,626	263,275	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 282,738	$ 9,932,813	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,405,852	$ 14,497,448	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,194,766	$ 3,084,493	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,180	9,180	28
29	Short-Term Notes Payable	1,499,000	1,499,000	29
30	Accrued Salaries Payable	314,923	314,923	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,136	37,136	31
32	Accrued Real Estate Taxes(Sch.IX-B)		339,590	32
33	Accrued Interest Payable		61,575	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	3,284,005	3,292,493	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,339,010	$ 8,638,390	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,534,200	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,534,200	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,339,010	$ 18,172,590	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,933,158)	$ (3,675,142)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,405,852	$ 14,497,448	48

*(See instructions.)

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,085,663)	1
2	Restatements (describe):		2
3	SEE ATTACHED SCHEDULE	(200,678)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,286,341)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(646,817)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (646,817)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,933,158)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,816,511	1
2	Discounts and Allowances for all Levels	(232,356)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,584,155	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	731,879	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 731,879	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,721	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	409,220	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	57,336	19
20	Radiology and X-Ray		20
21	Other Medical Services	92,353	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 560,630	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,019	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,019	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	261	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 261	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,885,944	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,406,789	31
32	Health Care	3,990,064	32
33	General Administration	2,469,153	33
	B. Capital Expense		
34	Ownership	3,009,663	34
	C. Ancillary Expense		
35	Special Cost Centers	545,402	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,532,761	40
41	**Income before Income Taxes (line 30 minus line 40)****	(646,817)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (646,817)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,957	2,117	$ 78,369	$ 37.02	1
2	Assistant Director of Nursing	2,507	2,618	71,611	27.35	2
3	Registered Nurses	25,292	27,617	619,348	22.43	3
4	Licensed Practical Nurses	44,703	48,168	851,136	17.67	4
5	Nurse Aides & Orderlies	114,064	119,169	1,011,745	8.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist			12,636		7
8	Rehab/Therapy Aides	8,451	8,451	50,706	6.00	8
9	Activity Director	2,021	2,182	33,662	15.43	9
10	Activity Assistants	19,016	20,301	168,292	8.29	10
11	Social Service Workers	6,552	7,081	83,431	11.78	11
12	Dietician	4,063	4,372	62,732	14.35	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	31,410	32,553	205,737	6.32	15
16	Dishwashers					16
17	Maintenance Workers	6,055	6,580	83,148	12.64	17
18	Housekeepers	25,421	26,390	193,965	7.35	18
19	Laundry	7,229	7,457	61,447	8.24	19
20	Administrator	2,168	2,448	117,062	47.82	20
21	Assistant Administrator					21
22	Other Administrative	1,676	1,892	89,379	47.24	22
23	Office Manager					23
24	Clerical	17,749	19,047	316,743	16.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,327	4,640	96,968	20.90	31
32	Other Health Care(specify)					32
33	Other(specify)	2,391	2,458	71,835	29.23	33
34	TOTAL (lines 1 - 33)	327,052	345,541	$ 4,279,952 *	$ 12.39	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	205	$ 8,755	01-03	35
36	Medical Director	monthly	45,000	09-03	36
37	Medical Records Consultant	48	2,160	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,672	10-03	39
40	Physical Therapy Consultant	66	1,849	10a-03	40
41	Occupational Therapy Consultant	66	1,954	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	1,578	11-03	44
45	Social Service Consultant	6	303	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	422	$ 65,271		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,064	$ 87,870	10-03	50
51	Licensed Practical Nurses	4,428	160,449	10-03	51
52	Nurse Aides	15,675	332,508	10-03	52
53	TOTAL (lines 50 - 52)	21,167	$ 580,827		53

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLES ROSS (01/01 - 04/01)	ADMINISTRATOR	NONE	$ 25,757
JEANETTE FOX (04/01 - 12/01)	ADMINISTRATOR	NONE	91,305
BARRY CARR	ADMINISTRATIVE	NONE	36,329
KATHY BRANDER	ADMINISTRATIVE	NONE	2,830
RAY DOLAN	ADMINISTRATIVE	NONE	15,537
PAT FINN	ADMINISTRATIVE	NONE	34,683
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 206,441

B. Administrative - Other

Description	Amount
MGMT. FEES - NUCARE SERVICES CORP.	$ 282,625
MGMT. FEES - ROBERT HARTMAN	120,000
MGMT. FEES - JLR MGMT.	120,000
MGMT. FEES - CAREPATH HEALTH NETWORK INC.	65,472
TOTAL (agree to Schedule V, line 17, col. 3)	$ 588,097
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	ACCOUNTING	$ 32,091
POWER SOFTWARE	COMPUTER	7,858
HEALTH DATA SYSTEMS	COMPUTER	7,534
HORIZON HEALTHCARE TECH.	COMPUTER	4,733
TRANSWORLD SYSTEMS	COMPUTER	598
AOL ONLINE	COMPUTER	178
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULT.	1,807
VARIOUS - SEE ATTACHED	LEGAL	53,187
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 107,986

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,633
Unemployment Compensation Insurance	82,425
FICA Taxes	308,910
Employee Health Insurance	149,121
Employee Meals	30,514
Illinois Municipal Retirement Fund (IMRF)*	
UNION PENSION	16,266
PAYROLL TAXES REIMBURSED	20,025
HOLIDAY EXPENSES	15,547
PAYROLL TAXES CITY	6,060
EMPLOYEE BENEFITS	31,170
TOTAL (agree to Schedule V, line 22, col.8)	$ 684,671

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 92
Advertising: Employee Recruitment	51,181
Health Care Worker Background Check	7,770
(Indicate # of checks performed 862)	
ILLINOIS COUNCIL	9,865
LICENSES, INSPECTIONS & PERMITS	2,118
DUES & SUBSCRIPTIONS	1,157
ALLOC. - CAREPATH	10,429
YELLOW PAGE ADVERTISING	260
SEE ATTACHED	2,471
Less: Public Relations Expense	
Non-allowable advertising	
Yellow page advertising	(260)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 85,083

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,493
ALLOC. - NUCARE	1,313
ALLOC. - CAREPATH	38
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,844

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number RENAISSANCE AT 87TH ST THE # 0042093 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS COUNCIL ON LTC $11,577**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **62,167** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **111,690**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **30,514** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees